

MDR Tracking Number: M5-04-2530-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 4-14-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$650** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The anesthesia for procedures on cervical spine and cord for date of service 4/14/03 was found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed service.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to date of service 4/14/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 7<sup>th</sup> day of July 2004.

Regina L. Cleave  
Medical Dispute Resolution Officer  
Medical Review Division

RLC/rlc

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IRO Certificate Number: 5259

June 14, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in neurosurgery. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by \_\_\_\_ or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

\_\_\_\_ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to \_\_\_\_.

#### CLINICAL HISTORY

\_\_\_\_ is a gentleman who is being treated for sympathetic dystrophy. Both neurosurgeon \_\_\_\_ and his pain management physician, \_\_\_\_, have agreed on this condition and feel that placement of a dorsal column stimulator would be the most appropriate treatment for the patient. It has required a couple of procedures to ultimately place that dorsal column stimulator in an acceptable position to cover the entirety of the patient's pain.

#### REQUESTED SERVICE (S)

Anesthesia for procedures on cervical spine and cord

#### DECISION

Approved.

#### RATIONALE/BASIS FOR DECISION

Anesthesia should be covered for this particular problem, as the underlying surgical procedure was appropriate.

There is certainly a growing body of evidence that shows that dorsal column stimulation is an appropriate treatment for reflex sympathetic dystrophy or

complex regional pain syndromes. In this gentleman's situation, as outlined in the letter by \_\_\_\_ in November of last year, a laminectomy had to be performed to make room for the spinal cord stimulator panel which is placed on the dura.

This is not an uncommon practice as these patients often have had previous surgical interventions and laminectomies or laminotomies are routinely done for their placement. Obviously, this is going to necessitate some degree of anesthesia. As stated above, the primary procedure was appropriate; therefore the anesthesia was also appropriate.